

SPECIALTY AEROMEDICAL TRANSPORT TEAM

(EMS Office Use Only)

Date Received

Date Issued

Date Expired

Certification #

Equip. Inventory [] EMS Report Form []

EMS Personnel []

APPLICATION FOR CERTIFICATION AS AN "OUTSIDE HOSPITAL"
EMERGENCY MEDICAL SERVICE
SPECIALTY AEROMEDICAL TRANSPORT TEAM

1. **ORGANIZATION/AGENCY INFORMATION**

A. Date of Application

B. Legal Name of Organization/Agency

C. Mailing Address _____
(Street)

(City) _____ (State) _____ (Zip) _____

D. Geographic Address
(if different (Street) _____
from above) _____
(City) _____ (State) _____ (Zip) _____

E. Name of Head of Organization/Agency

F. Telephone and Fax of Organization/Agency Head: (Business Fax) _____
(Business Phone) _____ (Home Phone) _____

G. For what type of specialty aeromedical transport team certificate are you applying?
(e.g., perinatal, neonatal?) _____

2. **INFLIGHT PATIENT CARE FORM**

Do you use the Alaska Medevac Transport Form? YES [] NO []

If "NO", attach to this page the inflight patient care form your organization uses.

If you do not have an inflight patient care form as required in 7 AAC 26.350 and 7 AAC 26.400(6), the Alaska Medevac Transport Form may be obtained from the Emergency Medical Services Section. Please indicate the number of forms you need: _____

3. PHYSICIAN MEDICAL DIRECTOR

List all physicians who are qualified under 7 AAC 26.630 and who agree to fulfill the responsibilities outlined in 7 AAC 26.610 - 7 AAC 26.700. (If your service has more than two physician medical directors, provide information about each.) If your physician medical director is affiliated with the Public Health Service or the military, please indicate state(s) of license and license number. The physician medical director(s) must sign below before the application is submitted.

A. _____
(Name--please print) (Alaska License #) (Physician's Signature)

(Specialty Training*) Board Certified? YES [] NO []
Board Eligible? YES [] NO []

(Aeromedical Training) (Training Organization) (Date Completed)

(Aeromedical Training) (Training Organization) (Date Completed)

B. _____
(Name--please print) (Alaska License #) (Physician's Signature)

(Specialty Training*) Board Certified? YES [] NO []
Board Eligible? YES [] NO []

(Aeromedical Training) (Training Organization) (Date Completed)

(Aeromedical Training) (Training Organization) (Date Completed)

*Training in the specialty for which the service is to be certified.

4. CONTINUING AEROMEDICAL EDUCATION

Name of person(s) responsible for continuing medical education program:

(Name) (Phone #)

(Name) (Phone #)

(Name) (Phone #)

(Name) (Phone #)

(Name) (Phone #)

5. EQUIPMENT INFORMATION

- A. Please attach a list of the medical equipment, drugs, and supplies which will be carried on the aircraft, when appropriate, for the special category of patients being transported. Your list will be reviewed by the State EMS Medical Director. Only equipment needed for each individual patient is required to be on the aircraft at any given time.
- B. Do you have sufficient equipment and medications to provide advanced life support procedures which are outlined in the standing orders signed by your physician medical director? YES ☐ NO ☐
- C. Specify equipment needed or missing and your plans to obtain it:
- D. Has all equipment been tested in the airborne environment to ensure that it works as designed at high altitudes and does not interfere with the operations of any aircraft in which it will be used?
YES ☐ NO ☐

6. AIRCRAFT INFORMATION FOR PATIENT TRANSPORTS

- A. Does the organization/agency have aircraft available 24 hours a day, 7 days a week, to provide patient transport except when flying conditions are unsafe or members of the service are responding to another emergency? YES ☐ NO ☐
- B. Does the organization/agency own the aircraft used for transporting patients? YES ☐ *NO ☐

*If "NO", list below the air carrier(s) with whom the organization/agency has written agreement(s) in order to provide available transport 24 hours a day, 7 days a week, and attach copies of agreements with this application. If there are more than two air carrier written agreements, submit information for each.

WRITTEN AGREEMENTS WITH AIR CARRIERS

<hr/>	<hr/>
(Legal Name of Air Carrier)	(Legal Name of Air Carrier)
<hr/>	<hr/>
(Mailing Address)	(Mailing Address)
<hr/>	<hr/>
(City) (State) (Zip)	(City) (State) (Zip)
<hr/>	<hr/>
(Name of Agency Head)	(Name of Agency Head)
<hr/>	<hr/>
(Business Phone of Agency Head)	(Business Phone of Agency Head)
<hr/>	<hr/>
(Agreement Starting/Ending Date)	(Agreement Starting/Ending Date)

- C. Please list below the type of aircraft either owned by the organization/agency or expected to be used through written agreement(s) and answer if each aircraft has proper restraining devices and litters. For organizations/agencies using more than eight aircraft, submit information separately.

AIRCRAFT TYPE			RESTRAINING DEVICES	LITTERS
MAKE	MODEL	YEAR	YES/NO	YES/NO
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

7. LICENSED PERSONNEL

List all certified or licensed personnel, such as Mobile Intensive Care Paramedics, Physician's Assistants, Nurse Practitioners, Registered Nurses, Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians involved in the transportation and care of patients. Indicate name; license level, number and status; status of aeromedical training; status of medical specialty training; and for personnel recertifying with the service, the number of hours (16 hours per certification period) of continuing medical education in specialized aeromedical patient transportation topics.

Name	Level of License	State License Number ¹	Expiration Date	Date of Initial Aero-medical Training ²	# Hours of Aero-medical Training in 1999-2000 ³	Completion Date	# Hours Special Medical Training	Name of Special Medical Training Organization	Completion Date

I affirm that the personnel listed above have had required aeromedical training.

(Printed Name of Physician Medical Director)

(Signature of Physician Medical Director)

(Date)

¹ If the service is not based in Alaska, please list the state in which personnel are licensed and their license numbers.

² This refers to department-approved training in accordance with 7 AAC 26.370 (a)(3).

³ This refers to special medical training in accordance with 7 AAC 26.330 (d)(2).

8. AFFIRMATION:

I hereby affirm that _____ will comply
(Name of Service)

with all rules and regulations of the Department of Health & Social Services

7 AAC 26.310 - 7 AAC 26.400, to include:

- 1) Having one or more certified or licensed Mobile Intensive Care Paramedics, Nurse Practitioners, Physician's Assistants, Registered Nurses, Certified Emergency Nurses, Critical Care Registered Nurses, or Physicians, who have had department-approved aeromedical training, and training in the medical specialty for which the service is to be certified, to provide advanced life support to each patient being transported;
- 2) Providing a continuing medical education program in aeromedical training that will enable certified or licensed emergency medical personnel to meet state recertification requirements in specialized aeromedical patient transport topics;
- 3) Ensuring the completion of an approved inflight patient care form for each patient treated. The form must document vital signs and medical treatment given the patient. A copy of the completed inflight patient care form must
 - a) accompany the patient to the treatment facility;
 - b) be sent to the physician medical director; and
 - c) be kept by the specialty aeromedical transport team as a permanent record for five years.
- 4) If advertising, listing in any advertisements the levels of certified or licensed medical personnel for its service.

(Name of Head of Agency/Organization)

(Title)

(Signature)

(Date)

9. NOTARIZED STATEMENT:

Please complete the section below:

(IN THE PRESENCE OF A NOTARY PUBLIC, POSTMASTER, CLERK OF COURT, JUDGE, MAGISTRATE, STATE TROOPER, OR AUTHORIZED STATE EMPLOYEE, IF SUCH OFFICIAL IS AVAILABLE, APPLICANT MUST SIGN HERE.)

I certify under penalty of perjury that the foregoing is true and accurate.

(Signature of Applicant)

(Date)

THIS IS TO CERTIFY that on this ____ day of _____, 200__, before me appeared _____, to me known and known to me to be the person named in and who executed the foregoing instrument and acknowledged voluntarily signing and sealing the same.

(Notary Public, Postmaster, Clerk of Court, Judge, Magistrate, State Trooper, or authorized State employee)

My Commission Expires

or

My Badge Number is